



CORE GROUP POLIO PARTNERS (CGPP) PROJECT

FY03 Narrative Report October 2002 – March 2003



Local villagers appreciate ADRA INDIA for providing health related services in addition to polio vaccination such as health camps, hand pumps, toilets, sewage clearing, etc. These “add-on” services have enabled ADRA to get involved in areas where they previously were not welcomed. One area in particular, Warsi Nagar, a slum in Zone 4 of Moradabad, where ADRA was previously not welcome, has now opened their door and this also leads to greater involvement towards eradicating polio.

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ANNEXES

ACRONYMS

ADRA	Adventist Development and Relief Agency
AFP	Acute Flaccid Paralysis
AMREF	African Medical Research Foundation
CBO	Community Based Organization
CDC	US Centers for Disease Control and Prevention
CCF	Christian Children's Fund
CGPP	CORE Group Polio Partners
CRDA	Christian Relief and Development Association (Ethiopian Umbrella NGO)
CRS	Catholic Relief Services
DHO	District Health Officer
EPI	Expanded Programme on Immunisation
ICC	Inter-Agency Coordinating Committee
IDF	Integrated Development Foundation (a partner of PCI India)
IEC	Information, Education, Communication
IMC	International Medical Corps,
IMCI	Integrated Management of Childhood Illness
KI	Key Informant (for AFP case detection)
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
NGO	Non-Governmental Organization
NID	National Immunization Day
NPSP	National Polio Surveillance Program
OPV	Oral Polio Vaccine
PCI	Project Concern International
PEI	Polio Eradication Initiative
PET	CORE Group Polio Eradication Team
PLAN	Plan International
PVO	Private Voluntary Organization
RSO	Regional Surveillance Officer (Nepal)
SC	Save the Children
SMO	Surveillance Medical Officer
SNID	Sub-national Immunization Day
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh State of India
USAID	United States Agency for International Development
WeSMCO	Welfare for the Street Mothers and Children Organization (Ethiopia)
WHO	World Health Organization
WV	World Vision

CORE GROUP POLIO PARTNERS (CGPP) PROJECT

FY03 Narrative Report (October 2002 – March 2003)

SECTION 1. EXECUTIVE SUMMARY

In late July of 1999, the Polio Eradication Team (PET) of the CORE Group Partners Project (CGPP) was formed to fulfill the terms of a grant from the USAID Global Bureau, Office of Health and Nutrition, Child Survival Division. The project has now been awarded \$11 million covering seven years for the Polio Eradication Initiative (PEI). The CGPP coordinates and mobilizes community involvement in mass oral polio vaccine (OPV) immunization campaigns in high-risk areas and the hardest-to-reach populations of polio-endemic countries. The CGPP also supports PVO involvement in AFP case detection and reporting. This period, 15 CORE polio projects were active in the following six countries: Angola, Bangladesh, Ethiopia, India, Nepal and Uganda.

The vision of the CGPP sees the involvement of CORE PVOs and NGO partners helping accelerate the eradication of polio. At the same time, the CGPP vision sees something of value being left behind that can be used to address other health priorities. The strategy to achieve the CGPP vision includes the following seven components (our mission):

1. Building partnerships,
2. Strengthening existing immunization systems,
3. Supporting supplemental immunization efforts
4. Helping improve the timeliness of AFP case detection and reporting,
5. Providing support to families with paralyzed children,
6. Participation in either a national and/or regional certification activities, and
7. Improving documentation and use of information for improving the quality of the polio eradication effort.

For each of the seven components listed above (our mission), project activities are being documented. In addition, a situational analysis of CORE program areas is provided with the following top priority recommendations by country summarized here:

1. **Angola:** In all four provinces where CORE PEI is working, the first priority is to maintain the good quality and coverage of NIDs that has already been achieved and to support the routine immunization system components essential to the polio eradication efforts (e.g., cold chain). The second priority in Benguela, Bie and Kwanza Sul provinces is to find ways to help improve the timeliness of reporting AFP cases as a means of improving stool sample collection.
2. **Bangladesh:** The first priority for polio eradication in the one Save the Children program area appears to be maintenance of the current high quality and coverage of NIDs. The second priority may be to improve the sensitivity of AFP detection in program areas possibly through community networks reporting directly to official reporting sites in two upazillas of the program area.
3. **Ethiopia:** The first priority for the CORE PEI program in Ethiopia is to maintain the current quality and coverage of NIDs and SNIDs. The second priority---when additional funding allows---is to help improve AFP detection and reporting in those zones classified as "silent" or "poor performing."
4. **India:** The first priority for CORE PEI India is to continue attempts vaccinating children in resistant villages and households (converting X marked houses to P). The second priority is for CORE PEI India to provide as much support as possible to the routine immunization system as it carries out its polio eradication activities.
5. **Nepal:** The first priority for CORE PEI Nepal---given that all key polio indicators are satisfactory for NIDs, routine immunizations, and surveillance---is to identify pockets of low performance within otherwise well-performing districts, if pockets do exist, and address any problems identified. The second priority, if funds allow, would be to expand and/or shift efforts to lower performing districts that are also at high risk for poliovirus importation.
6. **Uganda:** The first priority for AMREF and MIHV, as they continue supporting polio eradication, is to support the routine immunization system. The second priority is to continue supporting the surveillance system for AFP and other diseases.

SECTION 2. BACKGROUND AND STATUS OF THE CORE GROUP POLIO PARTNERS PROJECT

2.1 Background of the Project

In late July of 1999, the CORE Group Polio Partners Project (CGPP) was formed to fulfill the terms of a grant from the USAID Global Bureau, Office of Health and Nutrition, Child Survival Division. The project has since been awarded \$11 million covering seven years for the Polio Eradication Initiative (PEI).

The **vision** of the CGPP sees the involvement of CORE PVOs and NGO partners helping accelerate the eradication of polio. At the same time, the CGPP vision sees something of value being left behind that can be used to address other health priorities. Specifically, the three parts of the vision statement are the following:

1. Eradication of polio is accelerated by the coordinated involvement of PVOs and NGOs in national eradication efforts.
2. Collaborative networks of PVOs and NGOs are developed with the capacity to accelerate other national and regional disease control initiatives (in addition to polio eradication).
3. Relationships are strengthened between communities and international, national and regional health and development agencies.

The **strategy** to achieve this vision includes the following seven components (our mission):

1. Building partnerships,
2. Strengthening existing immunization systems,
3. Supporting supplemental immunization efforts
4. Helping improve the timeliness of AFP case detection and reporting,
5. Providing support to families with paralyzed children,
6. Participation in either a national and/or regional certification activities, and
7. Improving documentation and use of information for improving the quality of the polio eradication effort.

The CORE Group is uniquely positioned to serve in this capacity as it represents 36 US-based Private Voluntary Organizations (PVOs) which manage hundreds of USAID funded Child Survival projects worldwide. For this reason, PVOs are well positioned to address the challenge of global polio eradication in high-priority countries, such as those in conflict and those with extremely hard-to-reach communities.

This fiscal year USAID funds support 15 projects in Angola, Bangladesh, Ethiopia, India, Nepal and Uganda. Also, in each country, the CGPP supports a coordinating secretariat with at least one full-time coordinator/director. USAID mission funds wholly or partially support projects in Angola, Ethiopia and India. In India, mission funds have included “non-polio” health funding that allows the partners to address other interventions in the same communities. These “non-polio” funds allow the partners to include “add-on” activities that build trust between the community and the partners and therefore help break down resistance to polio eradication activities. In Ethiopia, the mission funds are provided to the Christian Relief and Development Agency (CRDA)---an umbrella organization representing over 200 NGOs in Ethiopia---to coordinate the funding and activities of PVOs/NGOs with the national eradication effort. With the funds from the Ethiopia mission, the CGPP has engaged PVOs and local NGOs in support focused on NIDs. In Angola and India, mission funds allow continuing projects to shift their efforts into high-risk areas, and are supporting new partners. A description of the situation in each country is provided below and in individual country annexes (annexes 2-7). A list of partners by country is provided in Annex 1.

2.2 Angola Situational Analysis

During October 2002 to March 2003, the CGPP provided funds to four PVOs in Angola for support of national polio eradication efforts. See Annex 2 for a more detailed summary of project information and a map of program areas. The four PVOs in Angola funded by the project during this entire period were Africare, CARE, CRS and Save the Children. These four PVOs worked in 16 municipalities across four provinces (Bie, Benguela, Kwanza Sul and Luanda) covering a potential beneficiary population of

572,221 children less than five years of age. Note that IMC (International Medical Corps) began receiving funds under this project at the end of this reporting period; IMC's activities will be documented in the next narrative report. Within existing resources, our current partners have been expanding as they are able into areas of the provinces that were previously inaccessible due to civil conflict that has now ended.

NID coverage by administrative estimate (number of doses of vaccine divided by the estimated number of children less than five years) is over 100% in the four provinces covered by the project. In contrast, national routine immunization coverage is very poor; DPT3 and OPV3 are estimated at 47% and 42%, respectively. (See Annex 2).

The non-polio AFP rate is greater than the standard one-per-100,000 children less than 15 years of age per year in all four provinces. This has improved greatly since 2000. In addition, the standard for timely investigation of AFP cases upon notification was met in all four provinces. In contrast, while improved from 2000, three of the four provinces did not meet the standard for "adequate stool sample" collection or "timely reporting of AFP cases"; only Luanda Province met the standard for these two indicators (93% and 100%, respectively). (See Annex 2). The data suggest that improving timeliness of AFP reporting rather than timeliness of investigation is key to improved stool sample collection.

Recommendations:

1. In all four provinces the first priority is to maintain the good quality and coverage of NIDs that has already been achieved and to support the routine immunization system components essential to the polio eradication efforts (e.g., cold chain).
2. The second priority in Benguela, Bie and Kwanza Sul is to find ways to help improve the timeliness of reporting AFP cases as a means of improving stool sample collection.
3. In Luanda Province, the second priority is to help maintain the quality of AFP detection and reporting and to strengthen the routine immunization system as much as possible during polio eradication activities.

2.3 Bangladesh Situational Analysis

In this reporting period, one PVO continued to work with the CORE PEI in Bangladesh under a no-cost extension. Previously, four organizations were being supported by the CGPP during the 2000-2002 period. Given funding constraints and the fact that no cases have been reported in Bangladesh since 2000, these four projects were allowed to finish as original funds were expended. This happened in spite of the fact that there is current intense transmission on its border with India and recent transmission (2001) in Burma/Myanmar. CORE PEI could continue to play an important role in Bangladesh by helping to prevent importation of wild poliovirus and by supporting timely detection and reporting of AFP cases if additional funds became available.

One organization, Save the Children, had sufficient funds remaining to cover expenses through March 2003. During this period, Save the Children worked in three upazillas in Chittagong Division serving a potential beneficiary population of 196,089 children less than five years of age. (See Annex 3 for more details).

NID coverage by administrative estimate (number of doses of vaccine divided by the estimated number of children less than five years) is over 100% in the three upazillas covered by the project. The nationally reported NID coverage figures are also very good with greater than 90% achieved in the 8th through 10th NIDs. Administrative estimates of routine immunization coverage in the SC program area are very good: DPT3 coverage is greater than 80% (closer to 90%) in all three upazillas. However, a population-based survey covering the district of one upazila (Nasirnagar) found DPT3 coverage to be 69%, well below the administrative estimate of 87%. National levels of routine immunization coverage as estimated by survey are poor: OPV3 and measles are estimated at 70% and 65%, respectively. (See Annex 3). These data suggest that supporting the routine immunization system may be a higher priority than improving the quality of NIDs.

The non-polio AFP rate is greater than the standard one-per-100,000 children less than 15 years of age per year in one of three project upazillas. In two upazillas, the non-polio AFP rate is below one but still

close to one; the failure to reach the standard rate for assessing the sensitivity of the AFP surveillance system may just be an artifact of having a small population with few AFP cases---one more AFP case detected in these two upazillas would have met the standard. The national non-polio AFP rate meets the standard. Stool sample collection, once an AFP case was identified, was timely and adequate. (See Annex 3). The data suggest that improving the sensitivity of AFP reporting is a higher priority than the timeliness of investigation and stool sample collection among notified AFP cases.

Recommendations:

1. The first priority for polio eradication in SC program areas appears to be maintenance of the current quality and coverage of NIDs;
2. The second priority may be to improve the sensitivity of AFP detection in program areas possibly through community networks reporting directly to official reporting sites in two upazillas.
3. The third priority appears to be the strengthening of the routine immunization system as possible during polio campaigns and in support of the AFP surveillance system.

2.4 Ethiopia Situational Analysis

During October 2002 to March 2003, the CGPP provided funds to two organizations in Ethiopia for support of national polio eradication efforts. See Annex 4 for a more detailed summary of project information and a map of program areas. The two organizations were one PVO (World Vision Ethiopia---WVE) and one Ethiopian NGO (Christian Relief and Development Agency---CRDA). CRDA hosted the secretariat and provided implementation funds to Africare, CCF, CRS, and SC. CRDA also provided implementation funds to Garbet Ledekuman and WeSMCO, both Ethiopian NGOs. ADRA, CARE and PLAN were non-funded partners this period in Ethiopia. These two organizations and funded partners worked in 44 woredas across 16 zones in six regions covering a potential beneficiary population of 920,805 children less than five years of age. Note that the funding level for the Ethiopia program has been less than the other PEI countries (but possible because of USAID mission support); this has made it necessary for CORE PEI Ethiopia to primarily focus its efforts on supporting NIDs and SNIDs rather than the full-range of activities carried out in other countries.



Northern Ethiopia (Amhara Region in this photo) has many hard to reach communities, that are isolated by geography, but that must be mobilized for NIDs and routine immunization.

Coverage of the last NID---measured by administrative estimate (number of doses of vaccine divided by the estimated number of children less than five years)---ranges from 55% to 134% in the zones where the seven organizations being funded for in this implementation period. However, within the specific woredas where CRDA/CORE is working, coverage during the last NID was greater than 95% in each of the seven partners' areas; the combined coverage in the woredas supported by the project was higher than the overall coverage reported for the zones (compare Table A4.1 with Figure A4.2). For six organizations, coverage improved between the first and second NID round indicating improvement in planning and implementation of NIDs (Figure A4.2 in Annex 4). Another key indicator of improvement is the distinct reduction in the number of zero dose children between the first and second NID round in all seven program areas (see Figure A4.3 in Annex 4). In contrast to NID performance, however, routine immunization coverage across the program area is very poor (Table A4.1). DPT3 coverage in 2002 ranged from a low of 4% to a high of 84% with an average of 39% (median 33%).

The non-polio AFP rate is greater than the standard one-per-100,000 children less than 15 years of age in only five of 16 zones supported by this project. The non-polio AFP rate ranges from 0 to 4.8. In addition, stool sample collection was adequate (>80%) in only six zones. Four zones are classified as "silent" zones and seven are classified as "poor performing" zones for surveillance.

Recommendations:

1. The first priority for the CORE PEI program in Ethiopia is to maintain the current quality and coverage of NIDs and SNIDs.
2. The second priority---when additional funding allows---is to help improve AFP detection and reporting in those zones classified as "silent" or "poor performing."
3. The third priority---if additional funding is found---is to improve the routine immunization system and routine immunization coverage. CORE PEI partners in Ethiopia should continue to look for ways to strengthen the routine immunization system in the planning, implementation and evaluation of NIDs and SNIDs.

2.5 India Situational Analysis

During October 2002 to March 2003, the CGPP provided funds to three PVOs and a secretariat in India for support of national polio eradication efforts. This period represents the beginning of Phase II of the CORE PEI program that began in 2000; Phase II is receiving primary support from the USAID India mission. See Annex 5 for a more detailed summary of project information and a map of program areas. The three PVOs in India funded by the project during this entire period were ADRA, Project Concern International (PCI) and World Vision (WV). These three PVOs worked in 46 blocks (and urban areas) in nine districts across four states (Bihar, Delhi, Uttar Pradesh, Uttaranchal) covering a potential beneficiary population of 2 million children less than five years of age living in 1,286 villages and urban wards. The beneficiary population of the program lives primarily in four "hot" districts in UP---considered a reservoir for polio---and in some of the endemic areas of Bihar and Uttaranchal and North Delhi (see figures A5.1 to A5.3 in Annex 5).

India is the only CORE PEI country that continues to have reported wild poliovirus in 2002 and 2003. The 2002 wild poliovirus case count for the districts in which CORE was working during this period was 195. The number of wild poliovirus cases reported in CORE blocks of these districts was at least 131, or 67%, of the 195 reported cases. Thus, CORE PEI in India is focusing on areas of intense poliovirus transmission in Phase II; Phase I of the program began in 2000 and was more widely scattered throughout India. Phase II focuses first on areas that had intense transmission in the low case year of 2001 (probable reservoir sites).

The primary focus of CORE PEI India in Phase I and II has been the support of NIDs, SNIDs and Mop-ups. CORE PEI programs in India, in the main, have not been asked to support AFP detection and reporting; for this reason, surveillance has been a minor focus of the CORE PEI program although the existing data has been used to determine geographic priorities. Providing support to routine immunization systems and helping families with paralyzed children have been other important activities of the CORE PEI India program.

NID coverage by administrative estimate (number of doses of vaccine divided by the estimated number of children less than five years) during the last NID round was good overall and very good in most of the CGPP funded program areas: coverage was greater than 95% in all CGPP-funded areas in the second NID round in February 2003. In addition, the overall coverage estimates of districts in which CORE PEI partners are working ranged from 81% to 160% with an average of 105% (median 101%, (See Table A5.1 in Annex 5).



**CORE PEI Polio
Champion: A rehabilitated
polio victim and World
Vision volunteer in Delhi**

As an indicator of improvement in the planning and implementation of NIDs, coverage in CGPP-funded areas improved between the first and second NID rounds (see Figure A5.4). We can also assess the value-added of the CORE PEI effort by comparing the percent of “X-marked” houses that were converted to “P-marked” houses between CGPP-funded areas and similar areas not receiving support from the CGPP. Figure A5.5 (Annex 5) shows that twice as many household were converted from “X” to “P” in CORE PEI areas as compared to non-CORE areas in the same districts. Some of the CORE PEI activities that likely account for this demonstrated added-value are shown in Figure A5.6, such as identifying migrant families and zero-dose children, counseling resistant families, and deploying additional house-to-house vaccination teams and “B” teams.

Another important factor that may account for better conversion of households from “X” status to “P” are the “add-on” activities funded by the USAID mission. Table A5.2 (Annex 5) lists some of the “add-on” activities being carried out in CGPP-funded areas. Most frequently carried out “add-on” activities to date have included the following: toilet construction, drain cleaning, medical camps, hand-pump installation, ORS distribution and de-worming. Since most of the “add-on” activities were just beginning in January 2003, we expect a higher level of outputs in the next six months. An expected outcome of this will be a continued reduction in resistance to polio eradication efforts as other community health needs are met and trust continues to build.

Routine immunization coverage in the majority of the CGPP-funded program areas is very poor per the 1998/99 National Health Survey. Coverage is not expected to have improved markedly. Only in Delhi is the immunization coverage estimated to be good (DPT3 = 80%). Estimated DPT3 coverage in Bihar and Uttar Pradesh is 24% and 34%, respectively. (See Table A5.1 in Annex 5).

AFP surveillance indicators are better than routine coverage indicators (Table A5.1). The sensitivity of the AFP surveillance system appears adequate as the non-polio AFP rate is above the standard of 1 per 100,000 children less than 15 in all districts where the CGPP is funding projects. The adequacy of stool sample collection is not uniform. Six of nine districts are performing below standard. The adequacy of stool sample collection ranges from a low of 50% to a high of 86% across the nine districts. While this appears to be an area requiring greater attention, most surveillance officers have not wanted CORE PEI India’s support. Where the surveillance indicators do not improve, however, CORE PEI India stands ready to help surveillance officers collect stool samples in a timelier manner.

Recommendations:

1. The first priority for CORE PEI India is to continue attempts vaccinating children in resistant villages and households (converting X marked houses to P). The current CORE India strategies appear to be working better than strategies used in non-CORE blocks. However, there is still much work to do, as many X marked households still have not been converted to P (at least 70% of X marked households were not converted). We expect that the “add-on” activities will help break down barriers to acceptance of vaccination.

2. The second priority is for CORE PEI India to provide as much support as possible to the routine immunization system as it carries out its polio eradication activities. We expect that the “add-on” activities will also provide some direct support for routine immunization.
3. The third priority is to provide support for stool sample collection---where surveillance officers are willing for this to happen---through involving CORE’s existing community contacts in detecting and rapid reporting of suspected AFP cases.

2.6 Nepal Situational Analysis

During October 2002 to March 2003, the CGPP provided funds to three PVOs in Nepal for support of national polio eradication efforts. The three PVOs in Nepal funded by the project during this entire period were ADRA, CARE and Save the Children. These three PVOs worked in 5 districts covering a potential beneficiary population of 400,329 children less than five years of age. See Annex 6 for a more detailed summary of project information and a map of program areas. In addition, PLAN International and World Vision have been non-funded partners of the CORE PEI program.

NID coverage by administrative estimate (number of doses of vaccine divided by the estimated number of children less than five years) is 98% or higher in the five districts covered by the project. Coverage of Mop-up campaigns is also high. [Mop-up coverage was lower than NID coverage in Mahottari District because this district used the previous March Mop-up coverage as the denominator, and used a process to better screen out children greater than five years---these figures probably reflect more accurate coverage estimates]. National routine immunization coverage is reportedly very good. DPT3 coverage is reportedly above 80% in all districts except one (Kavre) that has reported DPT3 coverage at 77%. (See Annex 6).

The non-polio AFP rate is greater than the standard one-per-100,000 children less than 15 years of age per year in all five districts. In addition, all five districts surpassed the standard for “adequate stool sample” collection of AFP. (See Annex 6).

Recommendations:

1. The first priority for CORE PEI Nepal---given that all key polio indicators are satisfactory for NIDs, routine immunizations, and surveillance---is to identify pockets of low performance within otherwise well-performing districts, if pockets do exist, and address any problems identified. Sub-district maps and use of GIS software and Lot Quality Sampling can help identify pockets of low-performing areas.
2. The second priority---if funds allow---would be to expand and/or shift efforts to lower performing districts that are also at high risk for poliovirus importation.



In Kanchanpur District, Nepal, CARE mobilized the community with a District Polio Cup football competition that raised awareness about polio eradication among spectators.



Many spectators observed the District Polio Cup football competition in Kanchanpur District, a social mobilization activity for polio eradication organized by CARE/Nepal.

2.7 Uganda Situational Analysis

During October 2002 to March 2003, the CGPP provided funds to two PVOs in Uganda for support of national polio eradication efforts: AMREF and MIHV. These two PVOs worked in 2 districts (Luwero and Ssembabule) covering a potential beneficiary population of 128,345 children less than five years of age. See Annex 7 for summary of project information and a map of program areas. Note that this period represents the final period of USAID funding for CORE PEI Uganda that began in April 2000. There have been no reported cases in Uganda since 1996.

NIDs are no longer being carried out in Uganda. SNIDs have continued in Uganda but not in CORE PEI program areas; AMREF has provided technical assistance to districts that have carried out SNIDs. NID coverage in AMREF's district (Luwero) in 2000 was over 98%. National routine immunization coverage is reportedly poor (DPT3 coverage was 46% in 2002 DHS) and routine immunization coverage in CORE PEI districts is very poor. DPT3 Coverage for DISH II Project Districts that includes MIHV's district, Ssembabule, was reported at 18.7% (DISH II projects are Masaka, Rakai and Ssembabule). DPT3 Coverage for DISH III Project Districts that includes AMREF's district, Luwero, was reported at 21.1% (DISH III projects are Luwero, Masindi and Nakasongola). (See Annex 7).

The 2002 non-polio AFP rate was greater than the standard one-per-100,000 children less than 15 years of age per year in both program districts. The 2002 adequate stool sample percentage met the standard of at least 80% in Ssembabule District where MIHV supports a village-level disease surveillance system; in Luwero this figure was 75%, just lower than the standard.

Recommendations:

1. The first priority for AMREF and MIHV, as they continue supporting polio eradication, is to support the routine immunization system. Improving the routine immunization system is important for preventing importation of polio or allowing vaccine-derived poliovirus to circulate and mutate to virulence and cause paralysis.
2. The second priority is to continue supporting the surveillance system for AFP and other diseases. AMREF should focus especially on improving the timeliness of AFP stool sample collection.

SECTION 3. REPORT OF ACTIVITIES BY MISSION STATEMENT

3.1. Build effective partnerships between PVOs, NGOs and international, national and regional agencies involved in polio

Building partnerships is an essential ingredient of the CGPP vision and mission. We believe that including PVOs and NGOs in existing national and international eradication partnerships will accelerate the eradication of polio. We also believe that the CGPP will develop new collaborative networks of PVOs, NGOs and partner communities and health authorities that can work together on other health initiatives after polio has been eradicated. The key CGPP strategies for building partnerships include the following:

- A functioning collaborative organization of PVO/NGO partners;
- Meet regularly with polio partners (MOH, USAID, WHO, Rotary, other ICC members) and brief these partners on CORE activities;
- Collaborate and work with local NGOs and CBOs to carry out or support project activities;
- Send CGPP representatives to all WHO Regional TCG Meetings.

Some examples of partnership building activities carried out during this reporting period are described in Table 1.

Table 1. Examples of CORE PEI Partnership Activities this Period by Country	
Country	Examples of CORE Polio partnership activities
Angola	CRS Polio Team made new contacts with previously inaccessible Catholic and Protestant Missions in all municipalities to involve them in the program activities, recruit, and train people as AFP Community Surveillance Volunteers and in identifying disable polio victims. CRS worked in close collaboration with UNICEF, WHO, the MoH, several churches (Catholic, Adventist, Methodist), Scout Boys, Traditional Birth Attendants (TBAs), women's groups and Traditional Authorities (Sobas, Seculos and Kandjangos) in polio eradication activities. CRS's new contacts, the Catholic Missions in Caimbambo and Chongoroi, offered to house CRS teams during their visits and were very interested to participate in the program.
	During her visit to Angola, Ms Ellyn Ogden, the USAID Worldwide Polio Eradication Coordinator met with the CORE Group Secretariat Director, who invited all CORE Partner's Country Directors. It was a good opportunity to clarify understanding about Mission's money pipeline for polio eradication and priorities and all present agreed that the experience of CORE should be a useful mechanism for other interventions.
	CORE Polio Partners (Africare, CARE, CRS, Save the Children and the Secretariat) met on 24 October 2002 in Kuito, the provincial capital of Bié. Africare, who also accommodated participants from other provinces, hosted the meeting. CORE Group also invited provincial health authorities, WHO Provincial Representative and Unicef Health Program Manager. It was a great opportunity to sit, for the first time, with project field staff around the same table and share experiences and points of view. It was also a good opportunity for participants to visit together a project site
	Dr. Antonio Dias, the Angola Secretariat Director participated, from 29 November – 07 December 2002, in the 10th Task Force on Immunization Annual Meeting in Abuja, Nigeria. Dr Dias also participated in all Angola ICC meetings, where the following issues were discussed: <ul style="list-style-type: none"> • Analysis of the NIDs' 2002 results, constraints and lessons learned • The National EPI budget for 2003 • National Measles Campaign for April-May 2003 • Preparation of Angolan Delegation o the 10th TFI Meeting in Abuja • The National EPI 5-years Plan of Action 2003-2007

Table 1. Examples of CORE PEI Partnership Activities this Period by Country

	<p>CARE and Africare continued to collaborate closely with each other. The two organizations occasionally “traded” community volunteers, ensuring that even as volunteers resettle within Bié, they remain with the project. MoH/PAV remains active in facilitating volunteer trainings this quarter in Kunhinga. For example, some activists trained by Africare in Kunhinga Municipality will be transferred to CARE’s custody, as Africare no longer operates in the area. In addition, CARE strengthened its partnership with MSF this quarter in Cuemba, their new project zones. The two organizations will work together in Cuemba to ensure timely identification of possible AFP cases and transport of samples to Luanda.</p>
Bangladesh	<p>SC participated in National, District and Upazilla level planning and orientation meetings for 11th NID. In addition, SC facilitated an NGO coordination meeting in all three districts/upazillas. A total of 15 NGO/CBOs participated.</p>
	<p>HOPE, a local NGO, worked with SC and involved their 60 field workers for polio eradication activities as a part of their routine activities in Nabinagar District (Upazilla). Two new NGOs, ARD and SDC, joined SC in Polio eradication activities in Nasirnagar District.</p>
Ethiopia	<p>Dr Filimona Bisrat, the Ethiopia Secretariat Coordinator participated in the WHO Task Force on Immunization in Nigeria.</p>
	<p>In addition to the five CORE PVOs (CRS, CCF, Africare, SAVE, WVE), two NGOs (Grarbet Ledekuman, WeSMCO), and three CBOs (Alem Tena Catholic Church Clinic, Sidam Development Program and Ethiopian Evangelical Church Mekane Jesus) were involved in the polio campaign. This led to a greater reach into remote and hard-to-reach areas.</p>
	<p>CRS, CRDA and Plan provided vehicles for visiting international Rotarians during the NIDs</p>
	<p>CORE members participated in the NID 2002 launching ceremony, attended by the Ethiopian President, Ministers, Religious leaders, Ambassadors and other prominent figures. This participation contributed to enhance the partnership between The CORE Group members, WHO and MOH.</p>
India	<p>Within the CORE PEI coalition, the partners worked together to ensure clear demarcation of geographically compact project sites in Phase II of the India program to avoid duplication of resources and efforts. Each PVO partner defined its coverage of villages/wards.</p>
	<p>Between January and March, ADRA participated in 27 coordination meetings at the district level. In addition, ADRA representatives attended over 200 community meetings and 14 Block PHC meetings.</p>
	<p>WV representatives participated in the District Task force meeting organized on 28th January 2003 at CMO Office Moradabad. Dr. Raja Ram (CMO), Moradabad was the resource person. Dr. Nanak Chand (DIO) said that we are partners and it is so clear in the field because community depends on the partners. He appreciated World Vision for manning 10 booths in Moradabad urban. In addition, he appealed to the NGOs to jointly work together in mobilizing the community, reducing the resistance and promoting the vaccine distribution.</p>
	<p>PCI successfully encouraged effective NGO partners---who had earlier worked with them in other districts---to shift to their program areas to priority “hot” districts.</p>
	<p>One of the ways to ensure effective project management was to introduce the process of Detailed Implementation Plan (DIP) for Phase II of the program, based on the USAID Guidelines on Child Survival Project. The CORE secretariat modified this to suit PEI requirements and shared it with all PVO partners. Two out of three PVO partners in India (ADRA & PCI) had no prior experience in writing DIP for USAID. In addition, although World Vision had experience in preparing a DIP, the PEI staff was altogether new to the process. Therefore, DIP workshops were organized for all three PVOs and their partners in December 2002.</p>

Table 1. Examples of CORE PEI Partnership Activities this Period by Country

	The CORE secretariat attended the 6th Meeting of the Expert Advisory Group for Polio Eradication in Lucknow, India to review the status of polio eradication, with particular emphasis on Uttar Pradesh, endorse the principles of the National Polio Plan of Action, and to review the strategy for improving routine immunization
Nepal	CORE Partners (Secretariat, ADRA, CARE, Save the Children) met together in December, February and March. These meetings were used to develop workplans, to debrief the partners about recent activities, and plan for expanded collaboration.
	Save the Children initiated a new collaborative partnership with two CBOs this period: Sagarmatha Social Development center (SSDC); and New Prathibha Samuh.
	CARE partnered with local NGOs/CBOs to host a 'District Level Polio Cup Football Competition' in Kanchanpur.
	ADRA met with their counterpart SMO and discussed improving reporting in frequently delayed reporting sites.
	At the request of WHO/PEN, the CORE Secretariat Director---Mr. Bal Ram Bhui---made study of status of AFP surveillance in Rautahat, Dhanusa and Mahottari districts in November by interviewing key surveillance personnel in district and visiting some of reporting units and reviewing the records the surveillance office.
	On March 19, CORE representatives attended the ICC meeting organized by the Child Health Division in Kathmandu. Representatives from various government bodies, UNICEF, WHO, USAID, JICA participated in the meeting.
Uganda	MIHV held a two-day meeting with the district medical officer to discuss future project and district activities in Ssembabule. Topics reviewed were immunization, BBDI survey and the collaboration on programs throughout 2003. MIHV also participated in numerous district-planning meetings related to health education and immunizations. Ongoing meetings were also held with the Local Chairman's I, II and III and LC5 to discuss the accomplishment of effective mobilization within the communities. MIHV staff attended a 1-day private sector development workshop to meet with other NGOs and CBO's. They networked and told other NGO/CBO staff in the district about MIHV's PEI and immunization efforts. In addition, the Peace Corps has been providing volunteers to support this project.
	AMREF collaborated with national NGOs and CBOs on Polio Eradication in the areas of Miginje, Kivumu, Wobulenzi and Kikyusa. AMREF also formed a new partnership with Community Health Promoters called "Share an Opportunity, and Capacity Building Group" in the management of child hood illnesses to increase Vitamin A supplementation, increase immunization coverage and detection of AFP.
<i>Sources: CORE PVO & Secretariat Narrative Reports</i>	

3.2. Support PVO/NGO efforts to strengthen national and regional immunization systems to achieve polio eradication

To achieve the CGPP vision of leaving something of value behind once polio has been eliminated from the CGPP countries, polio projects are strengthening the immunization systems in such a way as to support both polio eradication and other vaccine-preventable disease control programs. Types of system support provided by the CGPP include the following:

1. Technical and/or management training;
2. Cold chain assessments;
3. Improve cold chain and/or vaccine logistics systems;
4. Approach and encourage the private sector to support immunization efforts;
5. Support social mobilization to increase demand for routine immunization services;
6. Encourage community participation in, or contribution to, delivery of routine immunization activities.

Some examples of CGPP system strengthening activities carried out during this reporting period are described in Table 2 below by country.

Country	Examples of CORE Polio system strengthening activities
Angola	<p>CRS used cold chain equipment purchased with the Japanese Grassroots funds to open a vaccination fixed post in Malongo Catholic Mission health post (15 km outside of Chongoroi and 10 km south of the former Malongo quartering area) rehabilitated with funds from other source, aiming to improve the cold chain in areas detecting AFP cases and to improve AFP sample conservation during transportation.</p> <p>CRS also provided the MoH with 5,000 infant cards and 6,000 vaccination cards for Balombo, Ganda and Cubal municipalities and duplicated surveillance bulletins. In addition, CRS monitors the weekly vaccine stock and report from all municipalities via HF radio to the Provincial MoH and reports actual and possible vaccine stock ruptures.</p> <p>AFRICARE trained 15 vaccinators in Kuito, Camacupa and Kuemba between October and December 2002. And, with funds from other sources, constructed 2 new fixed posts of vaccination in Camacupa. AFRICARE helped supervise the Bie Provincial and Kuito Municipal Cold Chains and supported the transportation of vaccines and materials from Kuito to Camacupa and Catabola.</p> <p>In addition, Africare carried out social mobilization sessions in barrios of Kuito, Catabola, and Cunhinga to encourage population to attend vaccination. Health education about vaccine preventable diseases was carried out with the participation of 24,512 beneficiaries: 1390 men, 8649 women and 14473 children. Africare also conducted health education in the Caluapanda community kitchen (3,000 beneficiaries) to encourage mothers to attend vaccination and provide health education about vaccine preventable diseases.</p> <p>Through close collaboration with the traditional birth attendant association, AFRICARE helped track tetanus toxoid vaccination schedule of pregnant women during prenatal visits, sent newborn children to fixed posts for OPV0 and BCG during their first week of live and continues to follow-up those children until OPV3 and DPT3.</p>

Table 2. Examples of Activities to Strengthen Immunization Systems this Period by Country

	<p>In Kuito, CARE staff and volunteers identified 3222 children with zero or incomplete doses of polio—an increase over the last trimester. This increase reflects the greater number of house-to-house visits CARE made this quarter. However, it also points to generally low immunization coverage in Bie and the need for intensified efforts in this area. Children with zero/incomplete doses were referred to the nearest vaccination center / health facility, and then staff/volunteers followed up to make sure vaccinations were received.</p> <p>In Luanda, CARE trained 85 community volunteers and conducted 45 polio education and 5 theater sessions to increase community awareness about polio disease and prevention. CARE also carried out home visits to 2,079 houses to look for AFP cases and pass messages about polio. During these visits 1,176 children were sent to health posts in Palanca, Vila Estoril and Golf to complete their routine vaccination schedule. In addition, CARE provided the health centers of Escola Polivalente and Divina Providencia with 2,000 vaccination cards each.</p> <p>In Kwanza Sul, Save the Children provided transportation for vaccines and materials from Sumbe to Porto Amboim and Gabela and provided power electricity to the Amboim municipal cold chain. SC also reinforced supervision to vaccination fixed posts in Gabela, Sumbe and Porto Amboim and supported communication between the municipal and provincial MoH through mail transportation by car and by HF radio. For example, SC conducted six supervisory visits to the Gabela cold chain to observe vaccine conservation, daily records, and existing stock. SC also helped re-open the Gungo vaccination fixed post.</p>
<p>Bangladesh</p>	<p>SC conducted training on 'WHO 30 cluster sample survey' for 22 MoH field staff (Health Assistant) jointly with Civil Surgeon Office, Brahmanbaria during 18-20 March 2003. The objectives of the training was to develop a core group of health assistants on the survey techniques so that they can conduct 30 cluster survey at their respective working areas with little or no outside assistance. A major outcome of the training was, preparation of a set of survey questionnaire and completion of survey in all 30 clusters in Brahmanbaria district by themselves successfully. A coverage report was prepared in 'Bangla' with active participation of MoH district officials and field staff, which also were presented / shared at district health coordination meeting.</p> <p>SC, in association with MoH, organized a special EPI campaign in low coverage areas in all three upazillas to reach left out/ drop out children, update registration and ensure vaccination. The campaigns were organized in 150,104 and 32 low coverage sites in Nabinagar, Bancharampur and Nasirnagar upazillas, respectively. The month long campaign held in February in Nabinagar and Bancharampur, and in March in Nasirnagar. The campaign implementation included some of the following tasks: Identifying low coverage sites using routine EPI and NID reports; selecting community based volunteers (2 volunteer in each site) to work for registration and mobilization with MoH field staff; training for volunteers and MoH staff; House-to-House Registration day before vaccination by the volunteers and or MoH staff jointly; massive inter-personal communication in respective sites; and vaccination.</p>
<p>Ethiopia</p>	<p>A three day training workshop was organized by The CORE Group in collaboration with MOH, WHO, and UNICEF on "Communication/Social Mobilization on EPI/NIDs/AFP Surveillance." The training-workshop was organized primarily for regional health bureaus' IEC Focal Persons and PVOs/NGOs health professionals working in the area of immunization and polio eradication activities. The facilitators' presentation materials and Communication for Polio Eradication and Routine Immunization manual were distributed to participants to serve as reference materials at their place of work.</p> <p>WV provided logistic support for routine EPI in its project area.</p> <p>CCF maintained 4 refrigerators and 2 motorcycles in Sodo and Selte woredas.</p> <p>AFRICARE maintained refrigerators and motorcycles.</p>

Table 2. Examples of Activities to Strengthen Immunization Systems this Period by Country

India	<p>In support of the routine immunization system, ADRA identified over 5,000 under ones for vaccination follow-up in the January – March 2003 period alone. In addition, ADRA held 50 outreach immunization sessions and vaccinated over 700 children with relevant EPI antigens for age and vaccination status with “add-on” funding from the USAID mission.</p>
	<p>WV provided training on Routine Immunization and Polio for the volunteers of Sambhal Rural on 3 Feb '03. Dr. Dhakka was the main resource person to train these volunteers. A total of 32 volunteers and 2 supervisors participated in this training. The volunteers were trained on the concept of routine immunization and Polio disease. They were made to understand the transmission of virus in the body of 0-5 children. Mr. Prahalad Singh (HEO) also spoke on social mobilization and IPC.</p> <p>WV also conducted an RMP Doctor’s meeting on the of 2nd Jan’ 03 at Dr. Pasha Clinic, Kunderki. A total of 25 Doctors participated in this meeting. Dr. B.R.Tyagi (MOIC) was the resource person. In addition to supporting the polio eradication program, he appealed to the doctors to promote Routine Immunization coverage and raise awareness in the community regarding hygiene.</p>
	<p>In the January – March 2003 period alone PCI identified over 38,000 under ones for vaccination follow-up. In addition, PCI held 43 outreach immunization sessions, 262 BCC sessions, and vaccinated over 20,000 children with relevant EPI antigens for age and vaccination status during this same period using “add-on” funding from the USAID mission.</p> <p>PCI also increased its emphasis on coordination meetings at District and block levels to bridge the gaps in cold chain functioning and vaccination coverage. PCI ensured that all the Project Managers of partners NGO attended the district Task Force meetings. In addition, some partners are providing transportation facility for vaccine.</p>
	<p>Through its partnership with the Social mobilization forum, the CORE secretariat was able to obtain immunization IEC materials for the PVO partners from NPSP, State IEC Bureau, Rotary and UNICEF.</p>
Nepal	<p>In Kavre District, ADRA provided immunization education during literacy classes, and conducted an immunization quiz contest for 38 mothers groups. In addition, ADRA monitored the quality of routine immunization clinics, and monitored the cold chain at 3 sub-centers.</p>
	<p>Save the Children supervised 15 EPI Clinics in Siraha District, and encouraged health staff to conduct regular EPI clinics. In addition, SC supported electrical rewiring in the district’s cold room. SC also discussed immunization low coverage areas with the DHO in regular meetings and used these opportunities to decide on focus supervision in those areas. And SC conducted LQAS training for district supervisors, PHCI, HPI and SC staff.</p>
	<p>In Mahottari District, CARE helped the DHO to prepare and publish 150 copies of District Health Program Guideline Manual. The Manual has situation, problems, expected supervision activities, forms and format and necessary directions and instruction to health workers on all health programs including immunization. CARE also helped the district EPI supervisors and Cold Chain Assistant calculate the Ilaka-wide annual immunization logistics supplies. CARE developed a ward-level immunization reporting format in close coordination with district health office and supported the printing and distribution to all health facilities in the district.</p>
	<p>The CORE Secretariat facilitated a training session on Lot Quality Assurance Sampling (LQAS) at the Mid-Level EPI Managers' Training organized by WHO/PEN/UNICEF. It was interesting and exciting session where participants applied to methodology to validate UNICEF data.</p>

Table 2. Examples of Activities to Strengthen Immunization Systems this Period by Country

	<p>CORE initiated introduction of Geographic Information Systems (GIS) in its partners' MIS. In January, CORE trained 12 staff from ADRA, CARE, SAVE and WHO/PEN for 6 days on ArcView GIS software and use of global positioning system (GPS). The partners' staff appreciated the skills and expressed their interest in using GIS for information analysis.</p> <p>As an investment in the health systems of the districts CORE is working in, CORE developed digitized VDC level GIS maps for five districts. The maps have digital layers for the VDC boundaries, rivers, roads, and settlements. These GIS maps now can be used at the district for health system analysis as health information layers are added.</p>
<p>Uganda</p>	<p>MIHV supported integrated outreach sessions in the community on immunization and infant feeding in several sub-counties. A total of approximately 1,300 community members attended the sessions. Prizes were given to 18 children who completed their immunization on schedule. Mebendazole was distributed to children 1-5 years of age and 55 doses were given out. MIHV also supported District MOH immunization outreach by providing transport, fuel and lunch for health workers. In addition, MIHV held TBA supervision meetings that stressed the importance of children getting their immunizations.</p>
	<p>AMREF continued with cold-chain assessment in usage of DPT - Hep + Hip vaccines and adjustment fridge temperatures from 0 to +8 degrees Centigrade to between +2 to +8 degrees Centigrade. In addition, AMREF supported the DDHS in Luwero by transporting a freezer placed in Wobulenzi family planning to supply ice packs in the south Katikamu area and a fridge to Bukolwa Health Unit. AMREF also distributed new child health cards to health units.</p> <p>AMREF worked with mobilizers at the village, parish and subcounty levels, passing information to religious, institutions/schools to refer zero-dose children (those who have never been vaccinated against polio) for immunization and encourage care takers to register children at village immunization registers and inform them of the scheduled outreaches and static units. Also, AMREF supported the In-charges of immunization with transport to outreaches. In addition, AMREF worked with the DDHS to treat and immunize the sick during the outbreak of measles in Kikyusa sub-county, and participated in preplanning for mass measles vaccination for children 6 month to 14 years and vitamin A supplementation of children 6 months to 59 months, scheduled for October, 2003 in 56 districts including Luwero.</p>
<p>Sources: CORE PVO & Secretariat Narrative Reports</p>	

3.3 Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunizations

The CORE Group Polio Partners Project's main strength has been involvement in supplemental immunizations. This has led to many more children being vaccinated than would have without the availability of USAID funds for CORE PVOs. We believe this involvement--through planning and implementation of national immunization days, sub-national immunization days, and mop-up immunizations---is helping accelerate the eradication of polio. These efforts will inevitably strengthen routine immunization program activities also.

The following are the key CGPP strategies for supporting *supplemental immunizations*:

1. Participate in preparation of plans for NIDs, SNIDs or Mop-up campaigns
2. Participate in process evaluation of NIDs, SNIDs or Mop-up campaigns.
3. Identify areas or pockets of low OPV coverage and develop plans and strategies to increase coverage in those areas
4. Support social mobilization to increase demand for supplemental immunizations (NIDs, SNIDs, Mop-up campaigns)
5. Encourage community participation in or contribution to supplemental immunizations (NIDs, SNIDs, Mop-up campaigns)
6. Participate in implementation of NIDs, SNIDs or Mop-up campaigns
7. Participate in national or local-level cross-border planning, implementation and/or evaluation efforts.

In Table 3 below, examples of CGPP activities during this period are described.

Country	Examples of support for supplemental immunizations
Angola	<i>Not applicable as no supplemental immunizations were carried out during this period.</i>
Bangladesh	<p>SC participated in NID planning and orientation meeting at District and Upazilla levels, and developed a datasheet compiling all statistics of NID sites and a provision for continuous updating to ensure proper planning in priorities, services and coverage.</p> <p>SC also organized a meeting of the 'polio eradication task force-SC's local level initiative to mobilize all sectors' involvement in NIDs. In addition, SC carried out the following activities for social mobilization: rallies with the children of 146 schools, miking in 46 unions including hand miking in remote household level, miking from 1,259 mosques, displayed 180 banner, put on 33 video shows and 10 puppet shows major events for social mobilization for NIDs. The Audiocassette 'Let the world be polio free' (produced by SC) containing drama, polio song/music, and talk/dialogue created a festive mode during NIDs. The cassette was used in rallies, miking and in public places such as tea stalls, bus stands, and railway stations. WHO personnel supported the distribution of copies of the cassette in different parts of the country.</p> <p>All SC field staff persons were assigned to different NID sites with specific responsibilities for support.</p> <p>In addition, SC reviewed the list of isolated/pocket/public places and developed special plan of operation for those areas including support for mobile vaccination.</p>
Ethiopia	<p>AFRICARE participated in micro-planning activities with the Regional Health Bureau and gave an orientation to the community leaders and members of the Village Health Committees. Africare also conducted training for supervisors and Guiders. Seven supervisors and two senior program coordinators from Africare participated in supervision of the NIDs. In addition, two Africare vehicles and two rented vehicles were deployed in the first round and two Africare vehicles were used during the second round. Over five motorcycles were also provided.</p>

Table 3. Examples of CORE PEI Support for Supplemental Immunizations this Period by Country

Country	Examples of support for supplemental immunizations
Ethiopia	<p>CCF conducted sensitization meetings in four woredas and provided training for vaccinators and social mobilizers. CCF also participated in supervision of campaigns and follow up of problems identified. CCF provided vehicles for both NID rounds in four woredas.</p>
	<p>CRS participated in micro-planning activities in two woredas and conducted a launching ceremony in collaboration with the woreda health offices in two woredas capital towns. In Alem Tena town, Dugda Bora Woreda, around 436 people from the woreda administration council, government offices, religious institutions, peasant associations, communities from rural and urban areas participated. In Daye town, Bensa Woreda, launching ceremony was conducted at the Daye open Market and the number of people participated in the ceremony exceeded 352. The participants were community leaders from the rural areas, peasant association leaders, Kebele Development Committee, Traditional Birth attendants (TBA), government employees and urban dwellers. Students presented songs and dramas that reflected the importance of polio vaccine and routine EPI.</p> <p>CRS also conducted an orientation meeting for 106 religious leaders, peasant association leaders and prominent elderly people. The meeting discussed the purpose and importance of the campaign, the need for repeated doses of oral polio drops and their roles in mobilizing families to keep children under 5 years of age at home during campaign. In collaboration with woreda health offices, CRS also selected 138 volunteer mobilizers and provided training on NIDs, EPI and AFP surveillance.</p>
	<p>The Ethiopian NGO, Grarbet Ledekuman (GL), conducted a sensitization meeting with the peasant association, and community and religious leaders. GL also trained vaccinators and guides. In addition, GL participated in supervision and follow-up of problems identified. GL mobilized a total of 240 persons to participate in the campaigns (10 persons from Meskan and Mareko Health Offices, 73 officials of peasant associations; 148 vaccinators and guides; 6 staff persons of GL as facilitators).</p>
	<p>In Liben Woreda of Oromiya Zone, SC-US conducted sensitization meetings with the peasant association, and community and religious leaders. SC provided training for vaccinators and guides and provided vehicles to transport vaccine and vaccinators. SC also participated in supervision of the campaigns and follow-up of problems identified.</p> <p>In Jijiga and Shinele Zones, SC participated in micro planning exercises at the zonal level. SC also provided vehicles for two other Somali zones to transport vaccine and vaccinators to the vaccination sites.</p>
	<p>In collaboration with the Regional Health Bureau, the Ethiopian NGO, WeSMCO, conducted a launching ceremony in the capital of the Region. WeSMCO also carried out an orientation meeting for community and religious leaders and provided training for volunteer community mobilizers and supervisors. Vehicles were made available for both rounds of the campaign.</p>
	<p>WVE conducted a consultation meeting with regional, zonal and woreda health bureaus representatives. WVE covered a total of 12 woredas of which 3 are from Kembata Tembaro Zone, 3 from Hadiya Zone and 6 from Wolaita Zone. WV provided logistic support and facilitated social mobilization activities. WV also provided 10 rental vehicles rent and per-diem for participants (supervisors, mobilizers, consultation meeting participants).</p>

Table 3. Examples of CORE PEI Support for Supplemental Immunizations this Period by Country

Country	Examples of support for supplemental immunizations
<p style="text-align: center;">India</p>	<p>In preparation for SIAs during the Jan-Mar period, ADRA facilitated the social mapping of 230 villages and 77 urban wards/mohallas. In addition, ADRA carried out 150 children’s rallies, 12 street dramas, 234 community meetings, 28 meetings with religious leaders, and 100 counseling sessions with “resistant” families. ADRA also attended 27 District level coordination meetings and 14 planning meetings at Block PHC level. Similar activities, but at a lower number, were also carried during the November SNID.</p> <p>During SIAs in the Jan - Mar period, ADRA independently manned 180 booths and deployed over 300 volunteers at booths. ADRA also deployed 300 volunteers in house-to-house teams, deployed six monitors and mobilized 1800 school children. In addition, ADRA deployed 28 “B” teams and one “C” team. The independent booths covered 6,282 children. Similar activities, but at a lower number, were also carried during the November SNID.</p>
	<p>PCI facilitated the social mapping of the 125 villages and 10 urban wards during the Jan – Mar period. In addition, PCI carried out 329 children’s rallies, 3 street dramas, 805 community meetings, 233 meetings with religious leaders, and 421 counseling sessions with “resistant” families. PCI also attended 10 District level coordination meetings and 38 planning meetings at Block PHC level. Similar activities, but at a lower number, were also carried during the November SNID.</p> <p>During SIAs in the Jan - Mar period, PCI independently manned 13 booths and deployed 206 volunteers at booths. PCI also deployed 443 volunteers in house-to-house teams, deployed 39 monitors and mobilized 7,869 school children. In addition, PCI deployed 46 “B” teams. The independent booths covered 2,099 children. Similar activities, but at a lower number, were also carried during the November SNID.</p>
	<p>WV facilitated the social mapping of the villages in one block and 4 urban wards during the Jan – Mar period. In addition, WV carried out 37 children’s rallies, 22 street dramas, 60 community meetings, 22 meetings with religious leaders, and 765 counseling sessions with “resistant” families. For example, WV organized a polio rally at Sambhal. Mr. Virendra Kumar Pradhan of the village signaled the rally. A total of 100 children from Junior & Primary School took part in this rally. This rally was organized to make people aware about the need for children to receive polio drops on the booth day. The children Marched through the village holding banners and posters in their hands. The children recited polio slogans. WV also attended three District level coordination meetings and 20 planning meetings at Block PHC level. Similar activities were also carried during the November SNID.</p> <p>During the Jan & Feb 03 NIDs, WV independently manned 19 booths, deployed 280 volunteers in booths and 280 volunteers in house-to-house teams. WV also deployed 12 monitors, mobilized 50 school children and 43 “B” teams. The independent booths covered 6,232 children.</p>
<p style="text-align: center;">Nepal</p>	<p>During this period, ADRA helped organize the Kavre District NID micro-planning meeting and prepared social mobilization and communication plans. ADRA also mobilized and additional 102 vaccination booth volunteers. ADRA carried out miking through loudspeakers and provided transportation for logistics support and vaccine. In addition, ADRA provided an orientation to the 33 journalists from different daily, weekly papers and other media.</p> <p>ADRA jointly prepared monitoring plan with DHO for the NID and 20 ADRA staff monitored 72 immunization posts. ADRA conducted in-between NID round reviews and planning meetings. ADRA also assessed mass campaign immunization coverage using LQAS techniques.</p>

Table 3. Examples of CORE PEI Support for Supplemental Immunizations this Period by Country

Country	Examples of support for supplemental immunizations
	<p>In Kailali District, Save the Children conducted Street Dramas to promote polio vaccination in a new partnership with a CBO called New Prathibha Samuh. SC supported and participated in a Mop-UP Campaign Rally with schoolteachers, students and government staffs at DNP along with Street Drama at DNP.</p> <p>In Siraha District, Sagarmatha Social Development Center (SSDC), one of the NGO partners of Save the Children came up with idea of informing communities about NID day and on PEI messages through cyclists. Save the Children shared the idea with district health office and surveillance medical officer and all agreed to support the idea. The rally was kicked off by chief of District Health Office, Dr. Murali P. Singh in presence of SMO, Community leaders and Social Mobilization Office of Save The Children and news reporters. The cyclists wore polio vest, fit placards and posters on the bike, chanted NID slogans. They stopped in major community centers, gummed the posters on the household, distributed leaflets and pamphlets. It attracted people and was found to be an effective local method of mass communication.</p> <p>In Kanchanpur District, CARE carried out several innovative social mobilization activities. CARE organized a very popular District Level Polio Cup Football competition in addition to street dramas and miking. CARE also developed an NID Invitation Slip that was distributed to each caretaker in the district via FCHVs.</p> <p>CARE provided for an additional 13 Vaccination teams to cover high-risk areas and provided vehicles for vaccine movement and for supervision. In addition, CARE supported orientations for volunteers where the key issues on target children, high risk areas, vaccine wastage and search of zero reporting and paralyzed children were covered. In support of monitoring and evaluation, CARE developed a supervision plan that provided for monitoring of special areas of concern. All CARE staff was involved in monitoring vaccination with a special focus on those predetermined areas of concern. CARE analyzed SIA data and reviewed the data with the district public health officers.</p> <p>The CORE Nepal Secretariat Director visited Kanchanpur, Kailali and Siraha districts to monitor Mop-ups and NID during this period. One of his activities was to observe the Special Vaccination Teams working the India border checkpoints in Kanchanpur and Kailali districts. He also participated in the Inaugural Ceremony of Polio Cup Football Competition in Kanchanpur.</p>
Uganda	<i>Not applicable as no supplemental immunizations were carried out during this period.</i>
Sources: CORE PVO & Secretariat Narrative Reports	

3.4 Support PVO/NGO efforts to strengthen AFP case detection and reporting (and case detection of other infectious diseases)

The most important evaluation tool for the polio eradication effort is surveillance. Good surveillance is critical for both evaluating the effectiveness of polio eradication efforts in a country and for determining how the national eradication strategy should evolve over time. Good surveillance systems allow us to do two critical tasks: (1) determine where polio continues to be transmitted for purposes of mop up and increasing coverage; and (2) provide evidence that polio transmission has been interrupted.

The CGPP strategies for supporting *AFP Case Detection & Reporting* are the following:

1. Expand efforts to support and provide training in detection and reporting of AFP (and related forms of paralysis or other selected diseases);
2. Support MOH efforts to conduct active (rather than passive) AFP surveillance;
3. Support poliovirus outbreak and/or AFP/polio case investigations and/or response;
4. Support logistics network for the transport and testing of stool samples by reference labs; or,
5. Support timely distribution of updates on polio surveillance (e.g., bulletins, newsletters, presentations, meetings).

Some examples of CGPP AFP detection and reporting activities carried out during this period are described in Table 4 below by country.

Table 4. Examples of CORE PEI Support for AFP Case Detection/Reporting this Period by Country	
Country	Examples of support for AFP case detection and reporting
Angola	In Balombo Municipality of Benguela Province, four AFP cases were identified between October and March, one of them by a community member that CRS trained as a Community Health Volunteer for Active AFP Surveillance. CRS supported MoH on stool samples transportation to Luanda, for these AFP cases. Three CRS supervisors visited seven out of the nine municipalities to provide technical support to CRS mobilizers based in the interior and to conduct the project activities in the municipalities where CRS does not have a base. Every CRS base has a Polio motorcycle now. They are also available to support MoH's surveillance activities. To date, CRS has trained 3,478 Community Volunteer for AFP Active Surveillance, focusing on the interior municipalities, with the objective of teaching community members to recognize a possible AFP case and be aware that the health post is contacted in order to collect stool samples in a timely manner. The volunteers are being selected through churches and community groups (Catholic, Adventist, Methodist, Scout and women's groups).
	AFRICARE purchased and distributed 24 bicycles to community activists in Kuito. Bicycles are used to visit villages and to send timely AFP reports to MoH and Africare Health Coordinator. AFRICARE also carried out supervision visits to polio activists in Seminário Nambi, Ecovongo and Kuquema. In addition, AFRICARE provided transportation for MoH supervision and data collection of surveillance activities in the barrios of Kuito. Africare also provided transport to the MoH surveillance officer to confirm a suspected case of AFP in the Commune of Kuquema.

Table 4. Examples of CORE PEI Support for AFP Case Detection/Reporting this Period by Country

	<p>In Luanda, CARE made home visits to 3,684 houses for the purpose of conducting active surveillance of AFP cases and involve the community in the process. CARE also works in close collaboration with 8 traditional therapists in detection and reporting of AFP cases in Vila Estoril and Palanca.</p> <p>CARE in Kuito (project staff and volunteers) conducted 9,106 house visits to identify AFP cases (as well as checking vaccination cards and sharing information about polio transmission and prevention). CARE staffs are in the field on almost a daily basis conducting “on the job” supervision of volunteers. Between Oct and Dec 2002, a volunteer identified one AFP case in the IDP Camp of Chissindo. No cases of AFP were identified between Jan and March. However, staff identified several old, unreported cases of AFP in Cuemba, highlighting the need to begin active surveillance of AFP in this municipality. CARE trained 10 new volunteers in Kunhinga between Jan and March. And with the respective community authorities, CARE identified 30 others to be trained in April (in Cuemba, Andulo, and Catabola). Ninety-five of the 100 volunteers originally trained in Kuito continue to work with the project.</p> <p>In Kwanza Sul, Save the Children works in close collaboration with private health posts and traditional therapists to identify and report new AFP cases. SC made frequent visits and held meetings with community volunteers to motivate them in active surveillance of AFP through supervision and “on-the-job training.”</p> <p>Between Jan and March, SC-supported activists conducted 1,481 house-to-house visits for active AFP and other EPI target diseases surveillance. During visits activists look for incomplete vaccination schedule in children and mother cards and encourage parents to update calendar of their children. They also use interpersonal communication to increase awareness about vaccine preventable diseases. SC provided bicycles to 35 polio activists to facilitate active surveillance and timely reports. SC also provided activists with portfolios, notepads and pens; SC distributed soap among activists in order to motivate them in case detection and reporting.</p> <p>The CORE Group Secretariat and Partners participated in the International Review of AFP Surveillance in Angola held from 15 to 23 of October 2002. The international team of included Ms. Andrea Masters, Dr. Rebecca Prevots, Dr. Steven McLaughlin and Dr. Patrick Zuber from CDC, Ms. Ellyn Ogden from USAID, Mr. Hans Everts from WHO Geneva and Dr. Alex Gasasira from WHO African Regional Office in Harare. Dr. Ciro de Quadros participated as observer.</p>
<p>Bangladesh</p>	<p>SC held a follow-up orientation with staff members of different NGOs that included the status of AFP surveillance in the country with emphasis on active participation in reporting. 19 staff from JUSSS, LDSKS, GUC, VSEDO, PROSHIKA, NGO Forum and SC-USA took part in the orientation.</p> <p>SC displayed 16 billboards and painted one wall with AFP messages during the October-December period. Displaying billboards and writing walls in rural areas is one of SC’s strategies in disseminating the messages of EPI promotion, polio eradication and AFP reporting.</p> <p>One AFP case (Zamina) was reported by SC staff during this period and SC carried out the appropriate follow-up through SMO-WHO.</p> <p>SC distributed the EPI surveillance bulletin to 12 NGO/CBO partners.</p>
<p>Ethiopia</p>	<p>CORE Group Secretariat along with WHO developed background paper to implement community based AFP surveillance activities.</p> <p>CRDA/CORE in collaboration with MoH, WHO and UNICEF developed posters and stickers designed to serve as AFP surveillance IEC materials for community awareness raising against polio. Accordingly, 15,000 posters and 13,000 two different types of circular stickers were printed and distributed all over the country.</p> <p>Seventeen AFP cases were detected during both NID rounds in CORE Project areas; many cases were old cases, however.</p> <p>CRS, in collaboration with woreda health offices, trained 138 volunteer mobilizers to detect and report AFP cases, among other EPI and NID tasks.</p>

Table 4. Examples of CORE PEI Support for AFP Case Detection/Reporting this Period by Country

<p>India</p>	<p>WV organized a training on AFP & Polio on 3 Jan' 03 for the newly recruited volunteers of Sambhal Block. Dr. Arun Bhatnagar (MOIC) was the resource person. Dr. Arun emphasized more on Polio, he explained how the virus enters the body and affect the child. Mr. Subodh from CORE was present for this training. He discussed about the concept of PEI. A total 25 volunteers participated in this program.</p>
<p>Nepal</p>	<p>ADRA helped with the investigation and reporting of an AFP case to the SMO, and helped with the stool sample collection in Kavre District. ADRA also carried out a 60-day follow-up visit of an AFP case of Naldum VDC along with SMO. And ADRA provided education sessions on AFP detection and reporting during 38 mothers group meetings.</p> <p>Save the Children, in Siraha District, conducted an orientation on AFP surveillance to 38 newly appointed MCHWs. SC encouraged student health societies to report any AFP case detected in their areas. SC also incorporated AFP surveillance as a topic for discussion in Female Health Volunteers' quarterly workshop. In addition, SC provided an orientation to Birth Preparedness Package (BPP) Mobilizers on Integrated VPD surveillance, and carried out a one-hour session on AFP and Measles surveillance in district conference of Junior Red Cross Circle. The meeting gathered eighty secondary and lower secondary school students of the district. AFP messages were also disseminated through a Quiz and essay competitions.</p> <p>In Mahottari District, CARE visited zero reporting units to encourage timely reporting to the SMO and accompanied the SMO to active zero-reporting sites. CARE staff also accompanied the SMO during five AFP case investigations (Shamsi -3, Sonamai -1 and Nanhi - 1).</p> <p>CARE staff actively searched for cases of AFP, measles and neonatal tetanus during community visits. In addition, CARE disseminated AFP Surveillance messages to approximately 20,340 people through street dramas. And CARE supported a measles outbreak investigation in Megnathgorhanna VDC in wards 3,4,5 and 6.</p> <p>At the request of WHO/PEN, the CORE Secretariat Director assessed the quality of AFP surveillance in Rautahat, Dhanusa and Mahottari districts in November by interviewing key surveillance personnel in district and visiting some of reporting units and reviewing the records the surveillance office. Key recommendations of the assessment include the following: (1) send monthly updates and feedback to DHO/DPHO, PHO, EPI section and all active and weekly reporting units; (2) establish zero reporting from all health facilities; and (3) improve weekly dispatching of weekly reports (instead of several weeks' reports being handed in at the same time).</p>
<p>Uganda</p>	<p>MIHV supports the ongoing Village Level Disease Surveillance provided by volunteer data collectors. MIHV staff conducted a refresher-training course with surveillance volunteers and also TBA's regarding the birth, death, disability and immunization survey (BDDI). The DDHS continues to receive monthly MIHV BDDI data, which is utilized at District and National level. And, MIHV met with LC3's (sub-county political leaders) to distribute the complied BDDI information.</p> <p>AMREF worked with STOP (Stop Transmission of Polio) Team in Luwero District to assess knowledge and practice of health workers on AFP and Measles surveillance. IN addition, AMREF reviewed how to detect and report AFP with 648 village mobilizers, and held a refresher course for Health Assistants who are in-charge of the sub county and the parish mobilizers on detection and reporting on AFP.</p> <p>AMREF also supported the District Surveillance Focal People to investigate a suspected AFP case in Namusaale parish who was later found not to have AFP. Note that no confirmed polio AFP case has been detected in Luwero district in the last two and half years. The rate of AFP cases with 2 stools samples collected within 14 days has increased from 0% to 100% over the last two and half years as a result of training staff and providing them with logistical support for AFP surveillance</p>

Sources: CORE PVO & Secretariat Narrative Reports

3.5. Support PVO/NGO efforts to provide long-term assistance to families with paralyzed children

Through the CGPP effort, we expect that an increased number of polio and other types paralysis cases will be discovered. Because of this, we encourage CORE polio projects to provide assistance to families of children identified with paralysis (from any cause). If we make efforts to find paralysis cases, we believe it is our obligation to provide assistance to these persons and their families in some way that makes sense within the local context. Some examples of CGPP assistance for families with paralyzed children carried out during this period are described in Table 5 below by country.

Angola	<p>CRS distributed pairs of crutches in Cahala, Barragem, Cacumba, Mbala Kivula, Cavissolio and Cahata communities of Balombo. In addition, CRS has provided Health Posts with the translated version of "Guidelines for prevention of deformities in polio" (a WHO document translated into Portuguese by the CORE Group), to help both health workers and parents in physical rehabilitation of polio victims. CRS also encourages parents of under-five polio victims to complete the vaccination schedule for OPV and other vaccines.</p> <p>As the number of CRS Surveillance Community Health Volunteers increase, the number of disabled children identified also increases. The church network also is very helpful in identifying families with disabled children. CRS is collecting stories of disabled children to classify the cases as possible polio victims as in some cases the paralysis is due to trauma (violence/ accident) or neurological reasons and perhaps crutches are not useful. Four more polio victims were identified in Balombo between October and December 2002, and CRS identified eight more children with paralysis between January and March (3 in Balombo, 3 in Canjanla, and 2 in Cubal).</p>
	<p>AFRICARE identifies families with paralyzed children and integrates them with other projects beneficiaries (e.g. agriculture and food distribution). Between January and March, project staff identified one polio victim in Caluapanda community kitchen to whom they gave a pair of crutches.</p>
	<p>CARE in Kuito provides transportation to/ from health centers when a polio victim is in need of medical attention. In addition, project staff continue to register families with polio victims, and to target these families as beneficiaries in a recently approved 18-month Emergency Food Security project to be implemented by CARE in Bie. Part of the project is direct distribution to the most vulnerable households.</p>
	<p>Save the Children conducted home visits to families of paralysis victims and encouraged them to complete vaccination schedule. SC also provided crutches to paralysis victims; between January and March, project staff distributed nine pairs of crutches to children victims of polio.</p>
Bangladesh	<i>No activities were reported during this period.</i>
Ethiopia	<i>No activities were reported during this period.</i>
India	<p>WV's PEI coordinator has networked with DELHI COUNCIL CHILD WELFARE for 0-18 years children and teenagers to arrange medical & rehabilitation camps as following information were provided by DCCW:</p> <ul style="list-style-type: none"> ▪ DCCW has launched assessment camps for handicapped children in various areas in Delhi and outside Delhi. Those camps are held in association with Local organization, NGOs or with the support of the community people. In this regard WV's ADP in North Delhi PEI would like to organize a camp with DCCW. ▪ Every handicapped child in the community will be provided all necessity needs. WV's ADP North Delhi has started identifying Handicapped children from the project area for rehabilitation, surgery, disable certificates, railway concession certificates and to provide appliances etc. A medical camp is going to be held on 4th April in collaboration with DCCW and ADP North Delhi.

Table 5. Examples of CORE PEI Assistance to Families with Paralyzed Children By Country	
Nepal	<i>No activities were reported during this period.</i>
Uganda	MIHV completed the listing of children with disabilities in Ssembabule district using the BDDI survey and visiting schools in the district. Then MIHV held meetings with the Uganda Society for Disabled Children and discussed funding possibilities for children with disabilities within the project area.
	AMREF referred two children to the Luwero rehabilitation clinic for assessment and physical rehabilitation. Seven children with disabilities were referred to Katalamwa Rehabilitation Center for rehabilitation [3 had burns while 4 were crippled by polio]. Four children were provided with wheel chairs. And AMREF provided health education in the clinics and moral support to parents of disabled children.
<i>Sources: CORE PVO & Secretariat Narrative Reports</i>	



In Kwanza Sul, Angola, community volunteers in the Calundo community, who work with Save the Children, carry out a public drama about detecting and reporting AFP cases.

3.6 Support PVO/NGO participation in either a national and/or regional certification activities

Activities to certify that a country is polio-free vary across the CGPP countries as some countries continue to have polio transmission in 2002. For this reason, the main interest of the CGPP at this time is for collaborative PVO organizations to begin thinking about an appropriate role for PVOs/NGOs during their countries' certification period. No certification-related activities were reported this period.

3.7. Support timely documentation and use of information to continuously improve the quality of polio eradication (and other related health) activities

Information is necessary for maintaining and improving quality of polio eradication activities. Are the activities being done the right activities? Are they being done in the right way and at the right time? Answers to these questions can only come after appropriate information has been collected and analyzed. The CGPP strategy for the *information documentation* includes the following types of activities as well as others:

1. Count zero-dose children following supplemental activities and use information about distribution of zero-dose kids to improve plans to prevent zero-dose children in next round;
2. Document the percent of AFP cases with 2 stool samples taken within 14 days of onset of paralysis;
3. Document problems in logistics and/or implementation of supplemental immunizations and use this information to improve planning of follow-up supplemental immunization rounds;
4. Report to CORE partners the results of MOH or WHO clinical exams and laboratory tests of stool specimens---related to AFP cases identified in the project area during the prior reporting periods (polio, non-polio/discarded, pending).

Some examples of CGPP documentation and use of information during this period are described in Table 6 below by country.

Angola	In Benguela, CRS monitors the weekly vaccine stock, and helps report from all municipalities via HF radio to the Provincial MoH about actual and possible vaccine stock ruptures. Supported by WHO's new provincial representative, CRS continues working with MoH to establish an "Alert" stock level of vaccines in the municipalities, which would indicate the moment to re-order vaccines. However, stock ruptures occurred again in Bocoio, Caimbambo, Cubal and Balombo. And the provincial MoH continues to delay in promptly responding. MoH may still not understand the benefits of establishing an "alert stock."
	CRS and municipal health authorities have been discussing the possibility of having the register of newborn children integrated with vaccination activities. The conversations have been extensive; though, no action or conclusion from authority's side has been reached yet.
	AFRICARE conducted Knowledge, Practice and Immunization Coverage (KPC) surveys in Kuito and Camacupa (Bie Province) and in Waco Kungo and Kibala (Kwanza Sul Province). Preliminary findings were shared with CORE partners, UNICEF, WHO and the MoH. The report is not ready at this time.
	In Luanda, CARE conducted 30-cluster surveys in Vila Estoril, Palanca and Golf in order to access practices and measure the impact of polio messages. The analysis was completed and information used strategically. For example, when the results showed that caretakers took their children to traditional doctors if they showed signs of AFP, CARE began to collaborate with these doctors to ensure rapid AFP detection and testing, and proper rehabilitation. The results were also used to identify knowledge gaps in the population that the Kilamba Kiayi team should address. The results were shared with the CORE Secretariat.

Table 6. Examples of CORE PEI Documentation and Use of Information By Country	
	In November 2002, Dr. Antonio Dias (the Secretariat Director), Mr. Antonio Serafim José (the Secretariat Administrator) and Mr. Santos Completo (the Secretariat Logistician) visited CARE International Project Site in Kilamba Kiayi Municipality of Luanda. During the visit the team reviewed CARE Polio Eradication Project activities, provided feedback for improvement, and answered to questions of the CARE Polio Team.
Bangladesh	<p>During this period, SC documented the number of zero dose children found during the NID and prepared ward wise list for follow-up. SC also documented logistics problems during the 1st round of NIDs and followed up immediately for 2nd round.</p> <p>SC has extended its support through providing a computer with all accessories and training/on the job to the respective staff of the Upazilla Health Complex of Nasirnagar to accelerate documentation as well as use of information. The Civil Surgeon of Brahmanbaria was present in handover ceremony of the computer. The specific objectives of providing the computer are to keep track of all data/information regarding day-to-day EPI promotion, NID coverage, zero dose status and AFP reporting. This record keeping will help in generation of reports, analysis of the statistics graphically, and identification of low performing areas for immediate action.</p>
Ethiopia	All CRDA/CORE Group partners documented the number of “zero-dose” children identified during each round of the NID. The number of “zero-dose” children fell dramatically between the first and second rounds suggesting improved coverage of polio vaccine (see Annex 4).
India	ADRA identified 1,345 zero-dose children during the January and February NIDs for follow-up vaccination. In addition, during the campaigns ADRA has identified areas of poor coordination between the district and the block authorities that resulted in delays and late delivery of vaccines. In an example of a response, ADRA India provided 8 vehicles for the transport of vaccines during booth days to each PHC in Rampur district on the request of the CMO.
	PCI identified 2,026 zero-dose children during the January and February NIDs for follow-up vaccination. In addition, PCI identified problems for action during the NIDs. For example, the NID was organized during the harvesting session when most of the families were occupied in fieldwork along with their children; this makes it difficult for vaccinators and volunteers who must go each field for the vaccination. In addition, there was delay in distribution of vaccine carriers to the vaccination teams in Muzaffarpur district of Bihar. There also is a need to deploy more monitors for NID/SNID to improve quality and coverage. One monitor can visit 3-5 villages only. However, at present, the SMO deputed one monitor per block.
	WV identified six zero-dose children during the January and February NIDs for follow-up vaccination. In addition, WV identified problems in the way reporting formats were not shared with field staff and the way supervisors were cross checking. WV also documented the percent of AFP cases identified in Moradabad District that had adequate stool samples collected during 2002 (108/149)
Nepal	ADRA identified zero-dose children in Kavre District during both rounds of the NID. Three children above 12 months of age were found in Phalametar VDC. The primary cause of these older zero-dose children was that routine immunization had been interrupted due to the poor security situation of the past.
	Save the Children ---in Siraha District---assessed the immunization data of the District HMIS to identify areas of low and high coverage and used this information to decide which high-risk areas will receive special management attention. SC also helped document, compile and provide feedback on the report of INID and a six-month EPI analysis report to the EPI supervisor, PHO and DHO. In addition, SC provided the DHO and other health staff with an update on the status of global and national polio eradication efforts and AFP surveillance.

Table 6. Examples of CORE PEI Documentation and Use of Information By Country

	<p>In Mahottari District, CARE's analysis of 2001 Mop-up I & II round coverage data sparked insight on how to minimize the wastage rate. The wastage rate dropped from 23 % in 2001 to 11% during the 2002 Mop-ups. Vaccine wastage rate then decreased again from 6% and 7% respectively in INID II & I round in comparison to 11% in last Mop-up II round.</p> <p>CARE helped the DHO develop the immunization sections of the field and health facility level supervision checklists. CARE identified problems such as zero reporting units and in the conduct of routine immunization and shared this information with DHO, PHO, EPI Supervisors, Cold Chain Assistant and SMO. Accordingly action was taken to correct identified problems (e.g., shortage of Zero reporting formats, EPI registers, vaccination cards, syringes, etc.).</p> <p>At the request of WHO/PEN, the CORE Secretariat Director---Mr Bal Ram Bhui---carried out a record review with the SMO in Janakpur. According to records of weekly reports, Jaleswor and Bardibas have their last weekly report of week 33 and 22 respectively. Likewise Yaduka of Dhanusa has its last weekly report filed of week 18. However, the district's performance indicators showed timeliness of around 86% and completeness of 100% for the week 36-39. Actions to address these discrepancies have been taken up by the surveillance unit.</p>
<p>Uganda</p>	<p>During AMREF's review workshops with CORPs, 328 participants came with their village registers. Out of the 328 registers, 50 registers had twenty children who had never been vaccinated against polio (zero dose). AMREF then planned the establishment of outreach sessions in areas with zero dose children. AMREF also plans to sensitize the community by the village registers. In addition, AMREF held quarterly review and planning meetings in each of the 4 health sub-districts. Information on immunization coverage, timeliness of reporting and investigating AFP cases was shared.</p>
<p>Sources: CORE PVO & Secretariat Narrative Reports</p>	